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ABSTRACT

Described is the diagnostic teaching model developed by the Illinois Regional Resource Center to provide assessment and programing for children with unexplained handicaps. The model is explained to involve a multidisciplinary approach and to include six basic components: referals, information gathering, diagnosis, prescription, consultation, and followup. Listed among the steps to be taken in assuring success in the acquisition of comprehensive information are determining the type of information needed, determining who must be contacted to acquire such information, and keeping a record of the information received as soon as it arrives. Guidelines to consider when selecting diagnostic measures are offered; and examples are provided for reporting results of motor, sensory/perceptual, speech/language, academic, social/emotional, and self-help assessment. Examples are provided for implementing the following components of prescription planning: long-range objectives, behavioral objectives, time frame (schedule), current performance data, alternative teaching strategies, motivational strategies, and environmental strategies. Principles for implementing followup are outlined which include presenting the teacher with simple, but explicit instructions; assisting in the selection and design of appropriate instructional materials; and involving the receiving teacher in the diagnostic/prescriptive process. Sample forms are attached. (SBH)

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GUIDELINES FOR THE DEVELOPMENT OF AN EFFECTIVE DIAGNOSTIC SYSTEM

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PREFACE

The Illinois Regional Resource Center Diagnostic Teaching Model was developed in response to a request from the Bureau for the Education of the Handicapped to propose and implement model systems of assessment and programming for children with unexplained handicaps.

At the end of the project, January 31, 1977, the Illinois Regional Resource Center diagnostic classrooms, located in Normal and Peoria, had served 496 children in direct diagnosis and prescription. During the period from September 31, 1976, seven hundred and eighteen additional children were served by the replicating centers within the state. Since the beginning of the project in 1974, over 1200 children have been directly aided by the federal dollars expended by the RRC in Illinois.

Several replicating centers are now in the process of reporting their plans for the fall of 1977. It would appear that the number of diagnostic/prescriptive systems in operation at that time should nearly double those now operating. Since the RRC project will be terminated as of August 31, 1977, the proliferation of diagnostic systems will not be supported by RRC funds. It is obvious, however, that past federal support of this program has made possible the increase in diagnostic systems for handicapped students within the region of RRC #7.

THE DIAGNOSTIC MODEL

In order to create a diagnostic program which would be responsive to the needs of the wide range of children included in the category " . . . with unexplained handicaps," the Illinois Regional Resource Center (RRC) translated the concepts of assessment and programming into a diagnostic/prescriptive model.

It should be stressed that an effective diagnostic system can only be developed when the tendency to place children on a long-term remediation basis can be resisted. In most cases, diagnosis and program prescription can be accomplished within a time period of four to six weeks. Obviously, some cases take somewhat longer and others can be accomplished in a much shorter time. The effectiveness of the diagnostic/prescriptive classroom, however, is dependent on intensive work with each child in the area of assessment rather than remediation.

A multidisciplinary team approach is needed to develop an effective assessment and programming structure. Individuals whose expertise prove most valuable are the consulting diagnostic teacher, psychologist, social worker and coordinator, with clerical support. It is unnecessary for each of these individuals to devote full-time to the diagnostic system. Of the preceding individuals, the consulting diagnostic teacher is the mainstay

of the system. The services of the social worker and psychologist may be assigned as needed. A coordinator is necessary unless the diagnostic teacher is to be assigned the task of organizing and maintaining the program effort. It is also essential that clerical staff time be assigned to the multidisciplinary team to assist in preparing the reports and letters required by professionals. Other professionals such as mental health workers, psychiatrists, medical doctors and speech/language therapists may be contracted to participate on an individual case basis.

This multidisciplinary approach to diagnosis and programming is essential to the intent of Public Law 94-142 and the State Rules and Regulations for Illinois. Also, the expertise of each of the professionals involved in the individualized diagnosis makes a far more extensive evaluation possible.

The Diagnostic System

The system followed in the diagnostic model includes six basic components: referrals, information gathering, diagnosis, prescription, consultation and follow-up.

Referral

Each referral made to the diagnostic team should be presented by the team leader or coordinator at an intake staffing involving those personnel who will form the core of the diagnostic team. At this time the referral should

be carefully reviewed, assuring that the case is appropriate for the service which the team is able to provide. It has been the experience of the RRC staff and of the staff at the replicating sites that referrals may not be totally appropriate to the services available. Referrals which are judged to be inappropriate should be explored with the referring agent. In some cases, additional information will be required and in others the referral must be refused because it is inappropriate.

Referrals which are accepted should be recorded, discussed and assigned to a case leader. The case leader then becomes responsible for the information gathering.

Information Gathering

After the referral has been accepted, it becomes the case leader's duty to gather past information and assessment data on the child, to assign special staff members to gather information such as a social/developmental history or other background social work material, and to make the appropriate medical appointments to gather data on physical status. The gathering of all past information is important as new assessment becomes imminent. Comparison of former evaluations to current test results can sometimes provide revealing insights. It is also advisable to exhaust every avenue of historical information prior to initiating the diagnostic work-up.

Diagnosis

On-site diagnosis. The diagnostic teacher can, in many cases, provide effective diagnosis in the child's ongoing classroom setting. Many times, consultation with this specialist provides help for the child's regular classroom teacher who may need only to be assured that the methods being used are the most effective. When the problem is not complex, both formal and informal diagnosis can be accomplished on site.

The Specialized Classroom Setting. The diagnostic classroom provides an atmosphere which is conducive to indepth assessment of children having complex and difficult-to-diagnose learning problems. As previously mentioned, the diagnostic classroom, if it is used as a treatment center, will lose its diagnostic effectiveness. On a one-to-one basis with the diagnostic teacher and other team members, indepth diagnosis can be accomplished within a shorter time frame. If the problems to be diagnosed are behavioral, there is a drawback in bringing a child into a one-to-one situation. It has been the experience of the RRC team that behavioral problems should be assessed in the child's ongoing school setting in that the one-to-one isolated situation of the diagnostic classroom elicits a different type of behavior, e.g., the "acting out" child generally becomes compliant and seeks the teacher's attention without his usual nonconforming behavior.

However, essential diagnosis can be carried out for children with other handicapping conditions.

While the child is housed in the diagnostic classroom, specialists can be brought into the situation. This is an opportune time, with parent permission and attendance, to have the child reviewed by any medical personnel deemed necessary. During the classroom stay, both formal and informal diagnoses are accomplished by various team members.

Prescription Development

A program for the child is assembled based on the array of assessments. The various components provided by each of the team members are assembled into one report which displays all of the test results and their implication for the child's learning problem or handicapping condition. Based on these findings, very specific suggestions are made to develop an appropriate individualized educational plan for the child. Consideration must be given to the teacher who will be receiving the child into his/her classroom. The prescription should be detailed but not overwhelming in its bulk; concise and clear goals should be stated in conjunction with methods for achieving them and the media and materials required for their implementation.

Program Consultation

An exit or educational staffing must be held with the receiving teacher, parents and individuals from the receiving school who will be important in carrying out the child's program. Diagnostic team members who had input into the

prescription should also be in attendance at this staffing.

In most cases, this educational staffing becomes the placement staffing for the child. This may not be true in all cases. For example, there may be a question of the final placement of a given child even though the diagnosis is completed and the prescription has been made available to the sending school. Depending on the administrative organization of the diagnostic/prescriptive system and its relationship to the sending school, the diagnostic team may or may not be able to suggest specific educational placement for the child. This is the prerogative of the district or school itself. Under no circumstances should the diagnostic team write a prescription based on the availability of a particular type of class placement.

When the child has been entered in his new placement or has been returned to his former classroom, it is important that program consultation be provided for the receiving teacher. In many cases, the teachers have not been exposed to prescriptive educational planning and, consequently, may resist such specific goals and objectives. In some cases, materials may not be available to the receiving teacher, creating an impossible situation for implementing the prescription as written. It is essential that the diagnostic team member assigned to this consultation phase be exceptionally nonthreatening to the classroom teacher; at all times a helpful and understanding attitude must be displayed.

Follow-Up

An important step concludes the development of an effective diagnostic system, i.e., follow-up on the child. The duration of the follow-up period must be established by the diagnostic team. In general, the RRC has followed up on a three-month basis until a case is declared closed. Follow-up becomes important in reappraising and developing new programs for children who have had recurring difficulties. Effective follow-up requires a system of record keeping which brings the child's name to the team's attention at the pre-determined interval. Therefore, record keeping throughout the total process of diagnosis and prescription is essential. However, the particular record-keeping system adopted will vary with the particular circumstances of the diagnostic program.

Other Considerations

There are several other aspects of developing an effective diagnostic system which must be considered. One of the most important is gaining the cooperation of receiving teachers and administrators in implementing the individual educational programs which are developed. Of all problems noted by replicating teachers, this was the most severe. Teachers receiving a child after the diagnostic team work-up may feel threatened, may possess negative attitudes toward the child and the prescription and may, in general, fear attempting to implement the suggested program. An essential requirement

of the diagnostic system is the ability of all diagnostic team members to elicit trust and cooperation from the receiving school. The team must be able to present the educational program in such a way that it appears desirable and attainable to the receiving teacher.

A second problem which has been noted in developing the diagnostic system is one of promptly obtaining accurate information from outside agencies. Care must be extended to develop good relationships with other public agencies and with medical personnel; extra phone calls are often necessary to obtain the desired results. Individuals working directly with parents to obtain information should adopt a patient attitude and develop a form for obtaining the developmental history which allows for cross-checking information. Preparing parents in advance by requesting that they locate baby books and former medical records for use during the interview will help to provide an accurate developmental history.

It has also been noted that obtaining staff release time is often a problem. Staff must be provided the time necessary to attend staffings, to consult and to write reports. The allotment of staff time for these functions represents a primary administrative decision.

Again, it should be stressed that an accurate recording system capable of tracking children and their progress should be developed. The record system should also allow easy access for input and retrieval of information by the staff.

Guidelines for Implementation

The preceding description of the diagnostic model is intended to provide a general overview. However, greater specificity is required for application of the findings of the RRC study. The sections which follow are designed to provide experience-based guidelines for actual implementation in four major areas: information gathering, diagnosis, prescription and follow-up.

GETTING IT TOGETHER: INFORMATION GATHERING

The first step in the total diagnostic process is the collection of sufficient, relevant information from which to make effective diagnostic and programming decisions. Information gathered during this initial phase will determine the degree to which available diagnostic services will meet the needs of the child. Adequate background information will also assure the selection of appropriate referrals and foster the efficient use of the diagnostic team's services. The purposes of the information-gathering phase, therefore, are to obtain adequate and appropriate information to determine if a child will benefit from the available diagnostic services and to provide direction for further assessment of the child's specific strengths and weaknesses.

Objectives

To assure that these outcomes are reached, the following objectives must be met:

> Given a referral, the planning team will gather complete background information pertaining to the child's medical, developmental, educational, social and environmental history.
>
> After determining the type of information needed, the planning team will promptly obtain the necessary information.
>
> After acquiring the needed background information, the planning team will validate the information to assure its correctness, completeness and usefulness.

Several problems related to the comprehensiveness, promptness of return and validity of information requested may occur during this first phase of the diagnostic system. The following section describes a list of possible problems in each of these areas and alternative solutions to them.

Gathering Complete Information

- Problem: Parents, school personnel or personnel from outside agencies may be reluctant to release information or reveal information in order to prevent their "bias" from being considered in the evaluation.

  - Solution: A release form should be taken directly to the parents after the initial referral has been accepted. At this point, the team member should clarify the nature of services to be provided and obtain parental permission acquiring the information from other sources (see Sample Release Form, Attachment A).
  - Solution: The parents should be informed of their right to receive a copy of any written evaluation or report and to challenge its contents. The team member might also ask the parents if there is any information concerning the child which they do not wish to have included in the final report.
  - Solution: When requesting information from medical sources or other agencies, a letter explaining the reason for the request and the

type of information needed should be sent, along with the release form signed by the parents (see Sample Data Request Letter, Attachment B).

- Problem: Referral forms are returned with incomplete information.

  - Solution: Refuse to consider the referral until the missing information is supplied.
  - Solution: Schedule a conference with the parents, sending teacher or agency -- more information might be received during an interview.

- Problem: Needed records are not available.

  - Solution: If a child has moved frequently, past academic records may not have followed. In this case, a parent interview will be helpful in obtaining the necessary information.
  - Solution: The team must decide what information is relevant to diagnostic decisions. If information from past records does not apply to the child's present or future performance or program, it may not be important to the diagnosis.
  - Solution: Lack of information in the areas of developmental or medical history is particularly crucial. Personnel interviews with parents, physicians and other specialists may aid in acquiring missing data.

Obtaining Information Promptly

- Problem: Needed information is often not requested or sent promptly.

- Solution: In order to use staff time efficiently responsibilities for gathering information should be divided among team members. Care must be taken to outline each member's responsibilities during the first planning meeting if role confusion and misunderstanding are to be avoided (see Sample Assignment Form, Attachment C).

- Solution: The case leader acts as a coordinator and monitor of activities. Information should be logged as soon as it is received. A list containing the type of information required, source of that information, the team member responsible for collecting the information and the date the information is received will prove to be very helpful for organizational purposes (see Sample Recording Form, Attachment D).

- Solution: Follow-up letters or phone calls to agencies or schools help to speed up the retrieval process.

- Solution: Familiarize the diagnostic team members with resource persons who hold key positions in the organizations from which information is often requested. Secretaries may be very helpful in providing needed information quickly.

- Solution: Pressure applied to doctors and outside agencies by a child's parents may be helpful in obtaining prompt responses.

Validation of Information

- Problem: Occasionally, information from alternative sources may provide conflicting developmental, medical, educational or social data.

- Solution: Use two or more sources to validate the data. When conflict arises, look for the most consistent data to determine which impression is correct .

- Solution: Determine the relevance of the conflicting data and omit the information if it does not pertain directly to the diagnosis and/or prescription for the child .

Summary

In order to plan for and select appropriate diagnostic services, relevant information pertaining to the medical, developmental, social, educational and environmental status of the child must be collected. Acquiring sufficient and accurate information dealing with previous evaluations and services provided for the child will prevent overlap and duplication of diagnostic services.

To assure success in the acquisition of comprehensive information, the following steps should be taken:

1. Determine the type of information needed.

2. Determine who must be contacted to acquire such information, e.g., parent, teacher, physician, psychologist.

3. Develop a list of questions to be asked of each specific source.

4. Appoint specific team members to contact information sources and set a time for completion of this work.

5. Obtain the necessary contact to gather information.

6. Assign a case leader to coordinate information-gathering activities.

7. Keep a record of the information received as soon as it arrives.

THE SEARCH FOR A WAY: DIAGNOSIS

After sufficient information has been collected, the diagnostic process begins. The child's level of skill development is identified in the sensory/motor, speech/language, social/emotional, self-help and academic domains. By using a variety of observational and assessment devices, the diagnostician will be able to identify:

The child's current level of functioning in all areas,

Present deficit areas and learning problems,

The child's individual learning style and/or modality preference,

Priority needs and a hierarchical sequence for working toward them.

Objectives

To assure success in this phase, the following objectives must be met:

Given the collected referral information including previous diagnostic reports, the planning team will select appropriate measures for evaluating all developmental areas.

Given the assessment measures selected by the planning team, one or more members of the team will administer the devices to the child.

Given the results obtained from the selected assessment measures, the team will state the child's level of functioning (including specific strengths and weaknesses) in each domain.

Given the child's level of skill development in each domain, the planning team will identify and prioritize learning needs and primary modalities.

Selecting Diagnostic Measures

Because of the vast number and types of standardized tests, criterion-referenced measures and other diagnostic instruments published in recent years, it is difficult to determine which test to use and when to use it. The following guidelines should be considered when selecting diagnostic measures.

- Principle: Determine the purpose of the evaluation.

  If the purpose of the evaluation is to compare a child's performance with other children of the same chronological age or grade placement or to obtain rough estimates of the child's achievement level in several domains, a standardized test may be appropriate. This type of instrument provides a reference point in terms of the child's current functioning. Standardized tests fall short, however, when an in-depth analysis of a child's strengths and weaknesses or unique learning style is required. In this circumstance, a criterion-referenced measure would be more appropriate.

  - Example: The Wide Range Achievement Test (WRAT) may be selected to determine a child's present achievement level in reading, arithmetic and spelling. While this test yields a grade equivalent score indicating level of functioning, it yields little information in terms of specific skills the child has or has not acquired.

- Principle: Be sure the test actually measures what it purports to measure. Do not choose a test only by its name. It may be necessary to review the actual test items to determine if they appropriately measure a specific skill.

  - Example: One of the subtests on the Wide Range Achievement Test is called "Reading." Close examination of the subtest reveals that it merely assesses word recognition abilities and does not measure word attack or reading comprehension skills.

- Principle: Choose instruments which are appropriate for the child's chronological age. Most standardized tests are designed for a specific age range. If the results of the test are to be used to compare the child's performance with other children of the same chronological age, it is important to follow the standardized testing procedures. In this case, it would not be appropriate to administer a test to a child whose chronological age is over the age limits for that particular test.

  If a test is to be administered for diagnostic purposes, i.e., to identify a child's specific weaknesses in an area, and, if the evaluator does not plan to use the normative data for comparison with other populations, it may be appropriate to select a test

which has an age range that does not correspond to a child's chronological age.

○ Example: The Illinois Test of Psycholinguistic Abilities (ITPA) has an age range from two years, four months to ten years, three months. If an evaluator plans to administer this test to a child for the purpose of comparing that child's performance to the performance of other children the same age and if the normative data is to be reliable, this test should not be administered to a child over age 10-3.

On the other hand, if the evaluator is diagnosing a child who is over the age of 10-3 and who appears to be having difficulty processing auditory stimuli, he or she may wish to administer the ITPA. In this case, the normative data would not be reliable, but the evaluator could gain valuable information by examining the child's error patterns throughout the test. Here the evaluator is more interested in "intra-individual" differences (one child's specific strengths and weaknesses) than in "inter-individual" differences (how that child compares to other children of the same age).

● Principle: Determine if the instrument is appropriate for specific handicapping conditions. Few standardized tests have been developed for

or "normed" on populations of handicapped children. It is important, therefore, to select those tests which may be adapted for exceptional children. When examining an instrument, the evaluator should be aware of the tasks involved in the test, how the child will receive information and how the child is expected to respond.

○ Example: If the evaluator wishes to administer an achievement test to a child with cerebral palsy who cannot hold a pencil, it would be more appropriate to select the Peabody Individual Achievement Test (PIAT) rather than the Wide Range Achievement Test. The WRAT requires the child to write spelling words from dictation and to write answers to computational arithmetic problems. The PIAT, on the other hand, is designed with a multiple-choice format. No writing is required on any of the five subtests; the child responds by pointing to one of four possible choices. If the child cannot point with his hand, it is permissable for the examiner to ask for some other method of response. For example, the examiner may point to each choice and ask the child to nod or blink as an indication of his answer.

● Principle: When time allows, choose more than one instrument in each domain. By comparing a child's performance on tests which assess similar

areas but are designed with different content or method of response, the evaluator can obtain useful information about the child's unique learning style.

- Example: If a child does poorly on the Auditory Memory subtest on the ITPA, one might assume that the child has difficulty retaining information which is presented orally. In this case, the evaluator should administer a different test which measures auditory memory (subtests from the Detroit Tests of Learning Aptitude, for example) to see if the child's performance is consistent. The Auditory Memory subtest on the ITPA requires the child to repeat a series of digits in sequence, whereas, the Auditory Attention Span for Related Syllables subtest on the Detroit requires the child to repeat a complete sentence given orally by the examiner. If the child cannot repeat a series of three digits, but can repeat sentences containing ten words or more, it cannot be assumed that the child has a general auditory memory problem. It may be that he can remember meaningful material more easily than nonmeaningful material. The evaluator would probably not have discovered this on the basis of a child's performance on only one test.

- Principle: Be aware of the materials required for the administration of an instrument. While most tests include the necessary materials for administration, some instruments require large pieces of equipment or other materials which are not included in the box or a kit.

  - Example: To administer the Purdue Perceptual-Motor Survey, the examiner must have a balance beam, yard stick or broom handle, pillow or blanket and a penlight on hand. These pieces of equipment are not included with the test manual and record forms.

- Principle: Select instruments which are appropriate to the testing site. If the evaluation is to be conducted in the child's classroom or school rather than a diagnostic center away from his school, the evaluator should choose tests which are easily transported.

  - Example: Space should be considered; it would be difficult to assess gross motor performance in a room that measures five feet by six feet.

- Principle: Select instruments which can be administered in the amount of time allotted for the evaluation. The evaluator should familiarize himself with the recommended time ranges and/or limits for each test selected. While the administration of a

standardized test may require 30-40 minutes, another type of instrument (i.e., criterion-referenced) may be administered in 5-10 minutes and will provide the evaluator with the same information.

○ Example: The Gray Oral Reading Test requires approximately 40 minutes to administer depending on the child's chronological age and reading ability. An Informal Reading Inventory can be administered in half that time and yield the same basic information about the child's oral reading ability.

● Principle: Vary the instruments according to the child's interest and "attention span." By selecting tests which call for a variety of responses from the child and vary in the time required to administer them, the evaluator can make efficient use of the time spent with the child. Knowing that a child has an "attention span" of approximately ten minutes and that the child has difficulty performing fine motor tasks, the evaluator can arrange a series of tests that will hold the child's interest for reasonably long periods of time.

○ Example: The evaluator might select the Peabody Picture Vocabulary Test to administer first since this test takes only 10-15 minutes to

administer and does not require the child to write responses. Next, the Visual Motor Integration Test which requires the use of fine motor skills could be given. The evaluator might then administer one or more subtests from the ITPA which require oral rather than written responses. By sequencing tests in this manner, rather than administering four sequencial tests which require motor responses, the evaluator may be able to prolong the child's interest in the activities.

- Principle: Check to see if the desired instruments are available and/or easily accessable. There are few things more frustrating than discovering a test that is "perfect" for a specific situation and finding that it has been out of print for ten years or that it costs $250 and you only have $25.95 in the budget. It may be possible to order the test, substitute a similar instrument or develop an informal measure which will measure the same areas. If none of these solutions is feasible, it may be possible to borrow the test from another source. A college or university nearby may have access to diagnostic instruments. Check with the local school district, surrounding districts, other diagnostic centers or materials centers.

Planning for Test Administration

After the team has determined the type of information that is needed and the areas or domains which should be evaluated, it is time to organize the administration of the selected instruments or measures. Again, the following guidelines should be considered.

- Principle: Appropriately use the expertise of the team members.

  Some standardized tests require special training or qualifications on the part of the examiner. Many intelligence tests, for example, can only be administered by a certified school psychologist. A speech correctionist may feel more comfortable administering tests of speech and language rather than achievement tests; hearing evaluations should be administered by a trained audiologist.

- Principle: Determine which areas cannot be evaluated by the team.

  It may be necessary to contract for medical, neurological, psychiatric or visual examinations.

- Principle: Clearly define each team member's responsibilities as to the areas he or she is expected to evaluate.

- Principle: Set a time frame, schedule the evaluations to avoid overlap and set a definite deadline for evaluations to be completed.

- Principle: Develop methods for reporting the test results.

  Each team member who has been assigned responsibilities for the evaluation should report the test results in his/her given area. It is important to record which tests were administered, the dates they were administered and the results (see Sample Diagnostic Reporting Form, Attachment E).

Interpreting the Results of the Evaluation

Once the evaluation has been completed, the team must analyze the data and state the child's level of functioning in each domain. While test scores may be useful reference points, they provide little information in terms of programming for the child. For example, a score of "3.4" on the arithmetic subtest of the WRAT indicates that the child's overall functioning is at the third grade level; it does not indicate specific weaknesses in the area of mathematics. Can the child add three digit numbers? Can he "borrow" when there is a zero in the one's place? Can he add or subtract fractions? The score alone will not provide answers to questions of this kind.

The level of functioning should be clearly stated in behavioral terms, and strengths and weaknesses should be identified in each domain. The following examples may serve as a model for reporting test results.

Motor

Poorly Stated: Edward's gross and fine motor skills are poorly developed.

Well Stated: Strengths. Edward frequently engages in activities such as running, jumping, crawling, climbing and playing basketball.

Weaknesses. Edward has difficulty in balancing activities: he is unable to walk a long distance on a balance beam, hop on one foot or skip over a rope. He has difficulty in fine motor activities: he is unable to trace letters, copy simple line drawings or write numerals.

Sensory/Perceptual

Poorly Stated: Wepman Auditory Discrimination Test, Form II, 10/22/76. Edward has inadequate ability to discriminate sounds.

Developmental Test of Visual-Motor Integration, 10/18/76 VMI Age Equivalent 7-10.

Weaknesses.

a) Directional confusion

b) Reversal of forms

c) Inability to intersect lines

Well Stated: Wepman Auditory Discrimination Test, Form II 10/22/76. Edward could not state the difference between words

beginning with the "th" sound and those beginning with the "f" sound.

Developmental Test of Visual-Motor Integration

Visual-Motor Integration Age:	7-10
Chronological Age:	16-1
Date Administered:	10/18/76

Edward's paper and pencil abilities were very neat and controlled. He was able to copy a vertical and horizontal line, circle, cross, right and left oblique lines, square, right and left oblique cross, triangle, open-ended square and connected circle, three-dimensional cross, two-dimensional rings and eight-dot circle.

He was unable to copy directional arrows, diamond, tilted triangle, hexagon, horizontal diamond or three-dimensional ring.

Speech/Language

Poorly Stated: Strengths. Repetition of sentences was at the complex level.

Weaknesses. Edward's speech was intelligible although articulation errors of substitution were present.

Well Stated: Strengths. Edward could repeat sentences containing 10-12 words when these sentences were presented orally by the examiner.

Weaknesses. The following substitution errors were noted: f/v, v/w, w/r and s/z.

Academic

Poorly Stated: Key Math, 10/18/76 Total Grade Score: 0.7

Strengths.

a) Numeration and rate counting

b) Addition with visuals

c) Concrete areas of time such as identifying part of a clock or calendar

Weaknesses.

a) Subtraction

b) Mental Computation

Well Stated: Strengths. Edward can add numbers together using visual aids, sequence numbers from 1-40, write all numbers correctly except for the number eight and identify a circle, square, triangle and diamond.

Weaknesses.

a) Edward was unable to subtract two-digit or two-

and three-digit numbers when regrouping was required.

b) Edward was unable to subtract numbers from zero. When given two computations presented in sequence, Edward was unable to solve it by addition (example: 5 plus 3 plus 6 equals _____). Edward was unable to solve two computations presented in sequence when he first had to add and then subtract.

Social/Emotional

Poorly Stated: Edward is usually a sociable child but often refuses to participate in group activities.

Well Stated: Strengths. Edward enjoys being part of the group of children in the classroom. He engages in group activities after he has had a successful experience with the activity the children are doing. He interacts with the other children in the classroom and on the playground and asks many questions. He verbally defends himself and his property when necessary.

Weaknesses. Edward refuses to participate in a group activity where he has been unsuccessful. Prior to an

activity with a group, Edward should be allowed to experiment with the activity until he experiences some success.

Self-Help

Poorly Stated: Edward's self-help skills are slowly developing.

Well Stated: Strengths. Edward consistently eats with a spoon, dresses and undresses with no assistance and drinks from a glass.

Weaknesses. Edward cannot eat with a fork or cut with a knife. He has difficulty tying his shoes and often wears loafers so he can avoid this task.

Prioritizing Needs

After identifying and pinpointing specific deficit areas, it is necessary to hierarchically arrange and prioritize the child's needs in terms of skills and behaviors. One must look at both long-and short-range goals for the child. For example, if the child is presently exhibiting a behavior which interferes with academic or social development, the frequency of the disruptive behavior may have to be reduced before progress can be made in either area. If the child is hitting or kicking other children while interacting in a group activity,

the other children will not welcome his participation. Therefore, these behaviors must be extinguished and replaced with more appropriate social behaviors.

In the area of reading, we cannot expect the child to "develop a sight-word vocabulary" if he cannot visually discriminate between a "b" and a "d" or a "w" and a "v." In this case, the long-range goal might focus on developing sight-word reading and the short-range goal might center on developing visual discrimination skills.

Summary

We have examined various objectives which must be met to assure successful evaluation. If the appropriate steps are taken during this phase, the planning team will be able to identify a child's special needs and, based on this information, develop an effective prescription for a child.

The steps to be taken can be summarized as follows:

1. Select assessment instruments in each diagnostic domain which are appropriate for the child's age and handicapping condition.
2. State the child's level of functioning for each domain in behavioral terms.
3. Prioritize needs in hierarchical arrangement.

PRECISION PLANNING: PRESCRIPTION

All the diagnostic information in the world will not benefit an individual child unless it is presented to the receiving teacher in a form that can be readily understood and implemented. The overriding question which should be kept in mind as one prepares a prescription is -- Will the prescription enable a new or continuing teacher to implement an effective program for the child in multiple developmental areas?

Objectives

Specifically, this intent can be interpreted in the form of five objectives for prescription writing:

> Given diagnostic information for a handicapped child, the planning team will prepare an easily interpretable set of objectives in the areas of motor development, self-care development, social/personal development, cognitive development, perceptual development and communication development.
>
> Given a set of specific developmental objectives, the planning team will prepare a list of available tested materials and methods which can be implemented by the receiving teacher.
>
> Given the observed behavior of the child and verbal reports, the planning team will provide a descriptive set of procedures by which the child can be motivated to engage in new behavior and/or alter the existing behavioral pattern.
>
> Given observed behavior of the child in the classroom, the planning team will define specific environmental needs for the individual learner.

Given observed classroom performance and diagnostic information, the planning team will provide learning modality data for the individual learner.

Prescriptive Planning

Good prescriptions have three characteristics: they evaluate the information required to implement a program with an individual child, they cover all developmental areas and they contain easily interpretable information. In fact, a quality program prescription will represent an Individual Educational Plan for one year.

One way to insure comprehensive programming and the inclusion of all information required for its implementation is to develop a prescription format (see Sample Planning Form, Attachment F). Regardless of the particular format we use, the prescription should include:

- Component: The long-range objectives

  Long-range objectives should be prepared in each developmental area for a given child. The diagnostic measures administered will clearly indicate where deficiences exist and which areas constitute priority needs for the learner. However, these needs must be interpreted as one-year anticipated growth projections, i.e., How far would we reasonably expect a child to progress in a

given developmental area over the course of one year of instruction?

- Example: We might anticipate that a given learner would " . . . be able to perform simple motor tasks" but we would not expect a severely impaired learner to " . . . move freely in his environment and actively participate in recreational activities" as a result of one year of program participation. Long-range goals do not have to be stated as precise behaviors, but they must be narrowly defined, e.g., met in one year.

A set of long-range goals for a given student should be prepared across all domains; the following example illustrates a complete set of long-range goals for a specific learner.

Motor

Edward will be able to use a lawn mower to cut the grass.

Sensory/Perceptual

Edward will be able to listen to and follow a series of directions.

Speech/Language

Edward will initiate and carry on a meaningful conversation with members of his peer group.

Academic

Reading: Edward will be able to read and understand road signs, directional or other instructional signs and job applications.

Mathematics: Edward will be able to apply basic mathematical skills to telling time and making change.

Writing: Edward will be able to write his name, compose simple letters and fill out a job application.

Social/Emotional

Edward will be able to appropriately plan and use his leisure time.

Self-Help

Edward will be able to wash, dry and iron his own clothes.

● Component: Behavioral objectives

Long-range goals provide a general direction for programming, but they can be interpreted in many ways, some of which may be counterproductive for the child. Consequently, for each long-range goal, we should state the measurable behaviors (behavioral objectives) we anticipate. These objectives, in turn, will provide information on the required instructional strategies, and they will inform the teacher as to how the learner's progress should be evaluated. Each objective should include an observable behavior, the conditions under which we would expect it to occur and the criterion-measure for success.

○ Example: We're bound to have problems if the receiving teacher receives nonmeasurable objectives such as, "James will complete third-grade comprehension activities with 90% accuracy." or "James

will master the multiplication facts 0 to 9." The teacher would not know what to give James to test the objectives . . . what does it mean to complete comprehension activites?

Based on the long-range objectives, we should prepare a precise set of objectives in each subject area similar to the following examples for an individual learner:

Motor

Given a hammer, Edward will pound a nail straight into a defined series of points on the wood.

Sensory/Perceptual

Given a left-to-right series of pictures, Edward will describe a sequence of events indicating visual tracking from left-to-right.

Speech/Language

Given spontaneous conversational situations, Edward will correctly articulate the "th" sound on all occasions.

Academic

Reading: Given a third-grade reading book, Edward will orally read a story with no reading errors and respond to ten related comprehension questions with 85% accuracy.

Mathematics: Given 20 two-digit addition and subtraction problems, Edward will add or subtract the problems with

90% accuracy.

Writing: Given a topic of interest, Edward will write a complete sentence using correct punctuation.

Social/Emotional

Given free time for group games/activities, Edward will voluntarily participate on 90% of the occasions.

Self-Help

Given a self-care guide, Edward will brush his teeth, bathe, change his clothes and comb his hair daily.

- Component: Time frame (schedule)

  The objectives we develop will be of little use if they are subsequently filed away or reviewed only at the end of the year. The receiving teacher must view the objectives as a planning tool; the objectives should provide a target period for achievement.

  It's hard to specify exact dates for accomplishing our own goals. Specifying exact dates for students could create "havoc" and a great deal of disappointment. Time frames should be reasonable and afford some latitude in dates for achievement.

  - Example: If we say Edward will answer twenty addition and subtraction

problems correctly by December 1, 1978, we've put the teacher in a "very" tight situation. It may take the teacher until November 30 to even get Edward to the point of being able to sit down and work on twenty consecutive problems of any kind.

It would be far more reasonable if we indicate that within six months, Edward will have mastered the skill. In fact, it will be easier to project all objectives if we consider how long, in months, it will take for the learner to accomplish each skill.

- Component: Current performance data

We can't determine how much we've improved unless we know where we began. Consider, for example, the problem of weight control. If an individual didn't know he began the program at 360 pounds, he may not know how significant it is that he presently weights 290 pounds. It's the same thing with students. If we don't determine how often a child hits other students, completes a certain type of problem accurately or arrives in class on time, how will we determine when improvement has occurred? We must precisely define the present level of performance for all behaviors we hope to change. Further, our statements must be behavioral (measurable), and they must include a precise level of performance.

○ Example: The receiving teacher may not know where to begin if the best information we can provide is, "John has very poor self-help skills." What does "poor" mean and in what area? Or, would the teacher know what to do with a child that has a " . . . Frostig eye-motor of 4.3, figure ground of 4.3 and a form consistency of 3.0?"

We should be able to tell it exactly as it is, e.g., On ten observations, John's hair was combed only once; given ten form puzzles of four-to-eight pieces, Edward can complete none without assistance.

● Component: Alternative teaching strategies

Remember the objective of prescriptions: comprehensive, tested and easily implementable. This is not the time to be vague. We should be able to provide the receiving teacher with a sequence and a strategy for instruction that will work.

Specifically, the teaching strategy should include the optimal size of tasks for a learner, the level at which tasks should be designed, special characteristics of learning tasks, i.e., mobility, the level of independence with which the learner can perform and considerations when providing instruction to the learner.

With detail in these areas, the receiving teacher should be able to immediately establish a comfortable instructional situation. Using our instructions, the receiving teacher should also be able to create materials in areas where suitable activities are not available.

- Example: You could write a program for the learner that includes all the information required for instructional planning. The following summary prepared for a returning student indicates the type of material that might be included in a report.

> "Materials should be presented visually as much as possible since this appears to be Edward's stronger learning channel. Concepts should be presented by incorporating concrete materials that Edward can manipulate. Tasks should include an integration of all senses so that Edward is looking, listening and touching at the same time. Gradually reduce the visual stimuli as Edward's listenting skills increase.
>
> Edward tends to communication through gestures, and this should be allowed while his language skills are developing. Edward responds best to questions which require a simple one-word answer or in activities which require him to

point to an answer.

Include Edward in as many small-group activities as possible and encourage him to respond verbally. He is fascinated by machines and works well with a tape recorder or Language Master. He should be given independent activities where he has an opportunity to use this equipment.

It is recommended that academic and nonacademic tasks be carefully structured and that clear-cut goals be set for Edward. Time should be set aside each morning and afternoon to talk with him about upcoming activities of the day.

Academic tasks should initially require no more than 15 minutes to complete. Assignments should be kept to one page or worksheet at a time and gradually increased as Edward's academic skills develop. Instructions must be concise and direct. It is important that Edward repeat a series of directions to the teacher after they have been given to insure his understanding."

● Component: Motivational strategies

Optimal strategies and materials will have little effect if the learner is not "turned-on" to use them. While observing the learner, we should attempt to identify a variety of reinforcing alternatives that can be used to motivate him -- if, in free time, he does one thing more than others, it is a potential reinforcer. We should not forget the relative value of praise, charting behavior, attention and approval.

Also provide the receiving teacher with a list of events which are negative to the child, i.e., events that "turn the child off" -- things that should be avoided.

○ Example: A summary such as the following which describes the child's high interest activities will prepare the receiving teacher to arrange a positive experience for the learner:

> "Edward asks for the teacher's verbal approval at least ten times a day. It is recommended that simple tasks which Edward can do in the classroom, such as coloring, giving the date or watering plants, be selected to provide him with opportunities to assume responsibility and experience success. He should be praised while doing these tasks.

Positive reinforcement for the smallest accomplishment is imperative.

Edward responds well to gold stars or "happy faces" on his papers when he finishes a worksheet correctly. After Edward has been given an assignment and is certain of the instructions, his requests for approval should be ignored until the task is completed.

A token system was implemented to increase Edward's participation in group activities. He received a token each time he spoke to another student during play time, offered to share a toy or played with another child for ten minutes without leaving the play area. At the end of the play time (a ten-minute period), these tokens could be traded for a cookie (1 token), a candy bar (3 tokens) or five minutes of individual activity of his choice (5 tokens).

Edward's strongest reinforcers were found to be verbal praise, puzzles, five minutes in a small rocking chair and feeding the fish. He will work independently to finish assigned tasks in order to earn these privileges."

● Component: Environmental strategies

Some children respond well with very little structure; others require a highly-controlled environment. When considering environmental needs, we should ask if the child needs a rigid, fixed program or a varied sequence of activities. We should determine if the learner requires a self-contained situation, if he can meaningfully participate in a "normal" classroom setting for some activities or if he requires isolation to attend to a task or acquire control over his behavior.

We can then forward our observed data to the receiving teacher in a narrative statement describing what alternatives might be arranged.

○ Example: "Edward is a "hyperactive" learner. His hyperactivity is manifested in nervous habits such as slapping his head, wringing his hands and turning in his chair. These behaviors increase when he is required to attend to one task for more than 15 minutes, when assignments are too complex or when other children are moving around the classroom. Edward should work in a setting that has minimal distractions. Since he works best in isolation behind a screen or in a study carrel, it is recommended that

visual and auditory stimuli be kept to a minimum to reduce distraction.

Because Edward tires easily in the afternoon, a shortened school day is recommended. If this is not feasible, it is recommended that a rest period be incorporated into his daily schedule."

Summary

Planning effective programs is not a complex activity, but it is a precision process. To provide the receiving teacher with an optimal program, we should include:

1. Priority long-range objectives in each developmental area.
2. Behavioral objectives (measurable behavior, condition, criterion-measure) in each developmental area.
3. A reasonable, flexible schedule for reaching the objectives.
4. A precise level of current performance in each developmental area.
5. A set of teaching strategies which includes the task-size, the level of independence, characteristics of learning tasks and considerations when providing instruction to the learner.
6. A summary of procedures by which the learner can be positively motivated to participate and a description of aversive events which should be avoided.
7. A description of environmental alternatives that will facilitate learning, i.e., the degree of isolation in the classroom, the amount of structure in the learning situation, the areas in which the learner is able to participate in "regular" classroom activities and the amount of variation the learner can tolerate in programs.

SEEING IT THROUGH: FOLLOW-UP

We've now identified the particular learning problems of the child, and we've defined procedures with which to promote development in the classroom. The final step is crucial: we must assure that the prescribed program is implemented. Effective implementation will not happen by chance; it will require a deliberate, planned program. Receiving teachers will require support. For example, what will happen to our prescription if it just doesn't seem to work? What if the receiving teacher does not have access to the materials we've described? The prescription will fall flat; the learner will not progress.

We must also consider the possibilities that the receiving teacher will react negatively to the child, that the teacher may be apprehensive about implementing a precise prescription which may be uncommon in existing educational programs or that the teacher may not have the skills necessary to implement the prescription. Therefore, to assure the success of the child, we must first assure the success of the receiving teacher by providing adequate support and monitoring to successfully implement the program prescription.

Objectives

Specifically, the following objectives must be met:

Given a returning student, the case leader will arrange

sequential visits (observational) to determine problems and identify their sources.

Given a program prescription, the case leader will assure the availability of materials and facilitate and/or assist the teacher in defining alternatives based on the prescriptive/diagnostic information.

Given a negative reaction toward the learner by the receiving teacher, the case leader will facilitate positive attitudinal changes.

Given a receiving teacher who is apprehensive about program implementation, the case leader will provide support and information to reduce the fears.

Given skill-deficits on the part of the receiving teacher, the case leader will identify the deficits, arrange a non-threatening situation for teaching the required skills and implement the retraining program with the teacher.

Providing Follow-Up Support

Follow-up on an individual program requires that we consider four basic questions:

Is the student making clearly demonstrable progress?

Is the student receiving instruction/motivation which is consistent with his prescription?

Is the teacher able to interpret and implement the prescription?

Are we providing sufficient support to facilitate program implementation?

Given that an appropriate prescription has been prepared, positive responses to all of these questions can result through consideration of the following

guidelines for implementation.

- Principle: Present the teacher with simple, but explicit instructions. Instead of telling the teacher to " . . . work with John on motor activities," the teacher should be informed of the specific activities the child was working on when the prescription was prepared, e.g., "tying shoes, throwing a ball at a target, walking up stairs." Our instructions should be clear enough for an informed parent to understand them.

- Principle: Don't overwhelm the teacher; don't limit instructions to words. You may want to present information in gradual units rather than asking the teacher to work on all areas at once -- an instructional installment plan. Make sure apprehensive receiving teachers have the opportunity to experience success before asking them to implement the total prescription. In fact, you might want to isolate the priority areas which have the highest potential for successful implementation and start with them. Or, you could present the total prescription and ask receiving teachers where they would like to start. This procedure has the additional advantage of allowing the individual teacher to apply his/her expertise to the learning situation. Finally, it has proven more effective if the case leader discusses each step with the

receiving teacher rather than sending only a verbal report.

- Principle: Interpret data for the receiving teacher.

  The interpretation of data is important to both report writing and the subsequent discussion. For example, a teacher may have a great deal of difficulty interpreting a grade level of "4.6" into meaningful tasks. It would be better if we could describe the tasks the child could be working on and the learner's relative status in practical terms, e.g., "He can multiply two-digit problems; he comprehends third-grade reading materials."

- Principle: Assist in the selection and design of appropriate instructional materials.

  It may seem that the prescription alone would be adequate in this area. However, the materials we've used in diagnostic situations may not be available to the teacher. Also, the teacher may not be able to relate the learning needs we've described to the development of materials for use in the classroom. For example, we should be able to interpret " . . . visual mode, direct response materials . . ." into a meaningful set of activities to be used by the teacher. We should remember, however, to instruct rather than service -- the learner will be the teacher's continuing

responsibility. It may also be possible to assist teachers in capitalizing on existing state and regional resources by informing them of their location and the services provided.

- Principle: Model techniques for the receiving teacher.

  It's just possible that the receiving teacher may not know the meaning of terms such as "manual guidance," "overcorrection," "shaping," etc. When we discuss techniques that may be new to the teacher, we can facilitate their implementation by modeling their use with the child while the teacher observes.

- Principle: Provide direct training for the teacher.

  It would be "nice" if all prescriptions we wrote were implemented smoothly. But, sometimes the planning team makes mistakes. The best way to catch potential problems is to "debug" the program with the receiving teacher. To do this all you need to do is place the teacher in the student role; then, reverse the situation and let the receiving teacher apply the program with you carefully while you listen and observe. This procedure also provides an indirect method for instructing teachers in techniques with which they may not be overly familiar.

- Principle: Involve the receiving teacher in the diagnostic/prescriptive process.

  Why wait until the teacher "gets the child back" before eliciting

support? If you know who the receiving teacher will be or, if it is anticipated that a child will return to his sending classroom, bring the teacher in early. When dealing with disruptive behavior, for example, you might ask the teacher to observe and count the frequency of an incompatable, desirable response. Also, you might provide a simple prediagnostic checklist on which the teacher records the "present status" of the learner in all domain areas. Finally, you might conduct the initial diagnosis in the classroom or in an area where the teacher might easily observe the learner's response -- data that might lead to greater "understanding" and "acceptance."

- Principle: <u>Define the ultimate goals of your program in advance and relate the procedures to the learner.</u>

  As much as we hate to admit it, there are some youngsters that are so "difficult" the teacher may hope they'll be placed in a special program. It should be clear to the teacher that isolated new programming is not necessarily the end result. The objective is to provide better information on a child and a better program for him, i.e., the child might very well be returned with great benefit to both him and the teacher.

- Principle: Define roles clearly.

  Teachers may anticipate more from the planning team and the case leader than is realistically possible and beneficial. Unrealistic expectations can result in frustration and a basic lack of trust. Consequently, the activities, goals and intent of the team should be made explicitly clear at the onset.

- Principle: Provide positive reinforcement for the receiving teacher.

  Teachers are human and enjoy receiving positive consequences for their efforts. There are many positive ways to tell the teacher that the job's progressing well. For example, we could call the principal and tell him about it, we could inform parents of the teacher's high qualities, we could let them present at workshops relevant to their activities, we could identify them in newsletters or, more consistently, we could tell them personally what a great job they are doing -- not in vague terms, but in terms of "real" student accomplishments. In fact, one of the great potential reinforcers is the presentation and acknowledgement of learner progress as indicated by the difference between "present status" at the onset of the program and learner gain as indicated by ongoing recording.

- Principle: Set contingencies with the receiving teacher.

  We could suggest that the teacher independently implement the program. But, our support may be very desirable. If we ask teachers to commit themselves to implementing our program, we should also consider our part in the "contract." Both task sequences, ours and theirs, could be written as an effective check-off system which would make us accountable to each other and, as a consequence, to the individual learner.

- Principle: Don't abandon the teacher.

  We may be asking the teacher to perform a highly complex task; some teacher will reasonably need to have a little extra support. There are few things more difficult than complex, essentially foreign tasks and no assistance. The problem can be alleviated through ongoing personal or telephone contact; remember, the teacher is not the sole resolver of a child's learning problem. She is part of the same team we represent and should be viewed as a significant team member.

- Principle: Train other staff in the services you provide.

  Nothing elicits support like success and an informed population. Teachers should know what we do and the benefits we provided for them, the school and the children we serve. The creation of an advanced

positive attitude may one day facilitate appropriate programming for an individual child. Also, the degree to which the services you provide are used will depend, in part, on the awareness of other teachers as to what is available -- we can be of little assistance if the program is an unknown.

Summary

As you've probably noted, there's little difference between these guidelines and a successful instructional system. To be effective, the program you develop should:

1. Involve teachers in the process of preparing a diagnostic prescription.
2. Provide teachers with clear, easily implementable information.
3. Include direct teacher training for implementing the program.
4. Provide reinforcement for teacher successes in implementing the program.
5. Provide continuous support to the receiving teacher as the program is implemented.
6. Include information dissemination for parents and other staff members.

ATTACHMENTS

The completion of large quantities of "paper-work" is inherent to any comprehensive diagnostic system. While nc form suits all needs, a basic form can often be adapted to suit the particular needs of a program. The sample forms which follow have been successfully developed and used by implementing programs and, consequently, are provided as examples from which an efficient recording system can be developed.

The sample forms include:

Attachment A - Release Form

Attachment B - Data Request Letter

Attachment C - Team Assignment Sheet

Attachment D - Recording Form

Attachment E - Diagnostic Reporting Form

Attachment F - Planning Form

Attachment G - Referral Checklist

Attachment H - Child Observation Record

Attachment I - Case Contact Record

Attachment A

Sample Release Form

RELEASE OF INFORMATION TO: REGIONAL SERVICE AGENCY

DATE: _____ CENTRAL FILE NO. _____

I hereby consent and request _____
(Name of school, agency or agent)

_____
(Address) (City) (State) (Zip)

to release the following information pertaining to my child _____ to the Regional Service Agency for the purpose of conducting relevant education evaluation and planning activities. I understand that this release will be copied and sent with the request for such information.

Description of Records:

_____ Psychological	_____ P.T. & O.T. Report	_____ Medical Report
_____ Educational Assessment	_____ Audiological Report	_____ Student Plans
_____ Social Work	_____ Vocational Report	_____ Other
_____ Speech & Language	_____ Ophthalmological/Ocular	_____
_____ Parent-Infant Services	_____ Behavioral Assessments	_____

(Signature) _____ (Signature) _____
Parent or Guardian RSA Records Custodian

NOTE TO: _____ RE: _____ C.F.# _____
(Name)
_____
_____
_____

The information you provide to RSA will become a part of the above student's records and will be shared with the appropriate professional personnel responsible for the student's progress. All records concerning the above student, including the ones you sent to us, are open for review by the parents and by the student himself, in accordance with federal and state laws.

It is RSA's policy to maintain records only as long as they are determined to be relevant to the student's educational program by professional personnel and by the parents or student.

Attachment B

Sample Data Request Letter

Date:
Re:
Address:
Birthdate:

Dear

We understand that you have had involvement with the above named child. To facilitate our planning for this child, we are requesting that any information you may have regarding this child be forwarded to us. A release of information form signed by the parent (or legal guardian) is enclosed.

Your earliest response will be much appreciated.

Sincerely,

Regional Service Agency

Enc.
cc: RSA Central File

Attachment C

Sample Team Assignment Sheet

Child's Name _____ School _____

Address _____ Address _____

Date of Birth _____ District _____

Type of Information Needed	Person/Agency To Contact	Team Member Responsible	To Be Completed by

Attachment D

Sample Recording Form

Type of Information Requested	Person/Agency Contacted	Team Member Responsible	Date Information was Received
Parent Release Form			
RRC Forms			
School Records			
Therapy Records			
Medical Records			
Audiological			
Speech/Language			
Psychological			
Social Work Report			
Staffing Reports			
Optometrists Report			
Psychiatric			

Attachment E

Sample Diagnostic Reporting Form

Test Record Form

Child's Name _____ School _____

Address _____ Address _____

Date of Birth _____ District _____

Date Tested	Name of Test	Scores	Comments/Interpretation	Administered by

Attachment F

Sample Planning Form

INDIVIDUALIED EDUCATION PROGRAM PART I

Student _____ M__ F__
Address _____
City_____ State_____ Zip_____
Phone _____
Parent _____
Guardian _____
School District _____
Sup't. Res. District _____
Director, Sp. Ed. _____

Participants _____

Least restrictive educational environment:
Program _____ School _____
Teacher _____
Physical Education: Reg._____ Adapted _____
Justification for placement _____

Person responsible for implementation _____

Diagnostic Information (Formal or informal assessment: type, results and date)

Support Services (Type, facilitator, beginning and ending dates)

Interaction with non-handicapped students (programs, amounts of time)

INDIVIDUALIZED EDUCATION PROGRAM PART II

Student _____ Date _____

GOALS AND OBJECTIVES: (List annual goals, short-term objectives, media and materials).

Attachment G

Sample Referral Checklist

REFERRAL CHECKLIST	Student									
1. Learning or Emotional Problem Discussed with Principal and Resource Teacher										
2. Previous Parent Contact Made Reference Student Progress in School and Preliminary Screening Desired of Said Student										
3. L. D. Checklist Forwarded to Teacher										
4. L. D. Checklist Completed and Routed to Resource Teacher										
5. Observation and/or Preliminary Testing Completed By Resource Teacher										
6. Psychologist Contacted if Necessary										
7. Parent Advised of Need for Testing and Verbal Approval Obtained										
8. Referral Form of Teacher										
9. Referral Form Completed										
10. Nurse Notified to Obtain Health History and Written Permission										
11. Health History and Written Permission Forms Obtained										
12. All Forms Forwarded to Special Education Office										
13. Psychological Exam Administered										
14. Case Staffing Completed										
15. Parent Staffing and Written Approval for Placement by Parent Obtained										
16. Date of Placement in Program										

Attachment H

Sample Child Observation Record

_____ Initial On-Site Observation

_____ Follow-Up Observation

A. General Information

Date: _____ Name of Observer: _____

Name of Child: _____

Child's Current Placement or Program: _____

Observation Setting:

a) Name of facility or classroom: _____
b) Physical setting: _____
c) Time of observation: _____
d) Number and roles of adults present during observation: _____
_____
_____
e) Number of child's peers present: _____
f) Was child aware of observer's presence? _____ Yes _____ No
g) Is this setting part of the child's day-to-day environment? _____ Yes _____ No

B. Summary and Conclusions

1. Observer Summary. (Include a statement of any patterns observed in columns I-IV of the Child Observation Record. Be certain to note the rewards and punishments which were particularly effective or ineffective.)

2. If applicable, how does this Child Observation Record compare to previous observation records?

3. Observer Conclusions and Recommendations.(Use back when necessary)

H. CHILD OBSERVATION RECORD

Date: _____ Name of Observer: _____

Name of Child: _____

I. Child Behavior or Performance	II. Initiating Circumstances	III. Conditions	IV. Teacher/Peer Response	V. Comments

Attachment I

Sample Case Contact Record

Name of Child: _____ Birthdate: _____ I.D.#: _____

Date of Contact: _____

Type of Contact: (Check one)	Contact Persons: (Specify)	Purpose of Contact: (Check one)
___Phone	Resource Person _____	___Provide Technical Assistance
___Conference	Support Staff _____	___Gather Information
___Staffing	Medical Consultant _____	___Provide Information
___Home Call	Administrator _____	___Provide Training
___Letter	Sending/Receiving Teacher _____	___Give Demonstration
Other (Specify)	_____	___Receive Technical Assistance
_____	Parents _____	___Follow-Up
_____	Other _____	

Comments/Summary:

Date of Contact: _____

Type of Contact: (Check one)	Contact Persons: (Specify)	Purpose of Contact: (Check one)
___Phone	Resource Person _____	___Provide Technical Assistance
___Conference	Support Staff _____	___Gather Information
___Staffing	Medical Consultant _____	___Provide Information
___Home Call	Administrator _____	___Provide Training
___Letter	Sending/Receiving Teacher _____	___Give Demonstration
Other (Specify)	_____	___Receive Technical Assistance
_____	Parents _____	___Follow-Up
_____	Other _____	

Comments/Summary: